MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
P.O. BOX 58
JEFFERSON CITY, MO 65102-0058

PHYSICIAN'S REPORT FOR PHYSICAL REHABILITATION

The purpose of this report is to determine eligibility for physical rehabilitation benefits for the indicated injured employee. Please note the date of injury and complete the form according to the patient's condition at the time of the injury or initiation of rehabilitation. (The condition at the time of injury or initiation of rehabilitation may be different from present condition.)

Employee _____ Injury No. _____

Address _____ Injury Date _____

_____ SSN _____

Do you feel this injury qualifies as serious as defined by the attached **Statement of Policy?** ☐ Yes ☐ No

If NO, disregard the remaining questions and return form to address below.

If YES, please answer the following questions:

Injury diagnosis _____

The employee will/did require physical rehabilitation, physical therapy, and/or occupational therapy for the above

(please mark) ☐ Yes ☐ No

If physical rehabilitation is/was required, please give date treatment will/did begin:

_____

Please list complete name and address of facility where treatment was/will be received:

_____

_____

If it is too early to determine the need for physical rehabilitation, give an approximate date for us to inquire again:

_____

_____ _____

Signature (of person completing form) Physician Name

_____ _____

Title (if other than physician) Address (Street, PO Box)

_____ _____ _____

Phone (Area Code) Date Address (City, State, Zip)

Return to:

Fax: 573-751-2012

Mail: Attn: Rhonda Forck
Missouri Department of Labor and Industrial Relations
Division of Workers' Compensation
P.O. Box 58
Jefferson City, MO 65102-0058